Section 86-1.13 Groupings. (a) For the purpose of establishing routine and ancillary cost ceilings (for other than specialty hospitals), peer groups of hospitals shall be developed taking into consideration, but not limited to, the following general criteria:

(1) case mix;
(2) service mix;
(3) patient mix;
(4) size of facility;
(5) teaching activity; and
(6) geographic location.

(b) Based on the variables listed in subdivision (a) of this section, the commissioner shall establish a group for each facility in which the facility is at the center of its group--called seed clustering. The size of each group may be variable and shall be determined using acceptable statistical parameters which define the degree of comparability within each group. For the purpose of grouping in accordance with seed clustering, hospitals will be stratified to separate facilities located in the Blue Cross/Blue Shield of Greater New York region from facilities in the rest of the State.

(c) In the event a hospital fails to submit the data required for inclusion in a group which is developed in accordance with subdivision (a) of this section, the commissioner, on the basis of available data, shall develop proxy measures for the required variables, and based on these measures shall construct a peer group. The proxy variables shall not have a financial impact on any facility except that which failed to submit the requisite data.

Section 86-1.14 Ceilings on payments. (a) Reimbursement rate ceilings will be established as specified in this section for comparable groups ~~of medical facilities~~ (except specialty hospitals) developed in accordance with section 86-1.13 of this Subpart. The ceilings shall be established after the application of a wage equalization factor and a power equalization factor but prior to the addition of a factor to bring costs to projected expenditure levels during the effective period of the reimbursement rate.

(b) Facilities with ancillary costs less than 75 percent or over 125 percent of the peer group weighted average shall have such costs raised or lowered to the specified limits. The peer group weighted ancillary average cost of the respective groups shall then be recomputed with these adjustments. The original ancillary costs of such facilities shall be subject to the ceilings.

(c)(1) In computing the allowable costs for inpatient routine services for hospitals, no amount shall be included that is in excess of 107.5 percent of the weighted average per diem cost, using total expected patient days developed from application of the length of stay standards, of routine inpatient services of all hospitals in the peer group. For the purposes of this calculation, the total expected patient days shall also include imputed days. For the purpose of this computation, routine inpatient services shall not include capital costs, or costs of schools of nursing, ambulance services, interns and residents, supervising physicians and other physicians. In computing the allowable costs for ancillary services for hospitals, no amount shall be included that is in excess of 105 percent of the weighted average per discharge cost of ancillary services (including imputed discharges) of all hospitals in the peer group. For the purpose of this computation, ancillary services shall not include capital costs, costs of schools of nursing, ambulance services, interns and residents, supervising physicians and other physicians. In determining a facility's disallowances, its routine and ancillary ceilings shall subsequently be adjusted to consider differences in a hospital's case mix complexity relative to its peers.

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(2) For the purpose of establishing limits on allowable costs for interns and residents, supervising physicians and other individual physicians, no amount shall be included which is in excess of their operational cost per day in the prior year inflated by the price index used for physician services as developed in section 86-1.15 of this Subpart. For the purpose of this computation, other costs excluded from peer group ceiling calculations as set forth in paragraph (1) of this subdivision, shall not be included.

(d) For the purposes of adjusting the allowable costs for inpatient routine services for other than specialty hospitals, a total length of stay standard for each hospital will be developed which shall take into consideration the following variables:

(1) patient mix characteristics;

(2) whether the hospital is a teaching or nonteaching institution;

(3) the diagnostic mix of the hospital, including whether the hospital has a certified hospital-based ambulatory surgery service;

(4) presence or absence of surgery; and

(5) the geographic region the hospital is located in.

For the purpose of establishing standards a teaching hospital is one which has a special educational index greater than 100, as determined by the commissioner.

(e) For the purpose of establishing limits on allowable costs for a specialty hospital, a weighted average percentage change in operational cost per day from the prior year to the base year will be computed for facilities in that hospital's region. In computing the allowable cost for specialty hospitals no amount shall be included which is in excess of their operational cost per day in the prior year inflated by the aforementioned average percent change. For the purpose of this computation, costs excluded from peer group ceiling calculations, as set forth in subdivision (c) of this section shall not be included. In addition, reimbursement for specialty hospitals shall be limited to the movement in the application of the trend factor established under section 86-1.15 of this Subpart for 1984 and 1985 reimbursement periods. The allowances and pool distributions described in 86-1.11 shall be available to specialty hospitals pursuant to the conditions of that section.

* * *

(h) Limits on ceiling disallowances. (1) The total percentage of regional operational disallowances, excluding the minimum utilization disallowances, will be limited to the percentage of 1982 regional costs disallowed as a result of routine disallowances and one-half the length of stay disallowances, adjusted by a statewide adjustment factor, plus ancillary disallowances and the professional component limitation as set forth in subdivision (c) of this section. This maximum disallowance and the rate year disallowance subject to it will be adjusted to reflect appeals. Any excess disallowance in 1983 will result in proportionate relief to all hospitals subject to the disallowance within the affected region.

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86-1.15* Calculation of trend factor. (a) The commissioner shall establish a trend factor for allowable operating cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a medical facility's costs shall be weighted based upon data for the following categories:

(i) salaries;

(ii) employee health and welfare expense;

(iii) nonpayroll administrative and general expense;

(iv) nonpayroll household and maintenance expense;

(v) nonpayroll dietary expense; and

(vi) nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories. Included among these cost indicators are elements of the United States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(4) The cost indicators used in determining the projection factors shall be compared on a semiannual basis with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health. Based upon such review the commissioner may, in his discretion, either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

(5) This subdivision has been superseded by section 2807-a(8) of the Public Health Law. The commissioner shall implement adjustments to the trend factor semiannually; provided, however, that adjustments, except for the final adjustment, in the trend factor, shall not be required unless such adjustment would result in the weighted average of the operating cost component of the rates of charge limits differing by more than one half of one percent from that which was previously determined.

(b) (1) The maximum increase in allowable charges shall be calculated by the use of the trend factors calculated in accordance with the methodology described in subdivision (a) of this section.

(2) The maximum allowable increase in gross inpatient charges shall be the product of allowable 1982 gross inpatient charges, the 1983 trend factor, and the ratio of 1981 inpatient costs to 1980 gross inpatient charges.

* Used in the calculation of rates for the period January 1, 1983 through December 31, 1987.

(3) The provisions of this subdivision shall expire on December 31, 1983.

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Section 86-1.16 Adjustments to provisional rates based on errors. Rate appeals pursuant to section 86-1.17(a)(1)-(2) of this Subpart, if not commenced within 120 days of receipt of the commissioner's initial rate computation sheet, may be initiated at time of audit of the base year cost figures upon or prior to receipt of the notice of program reimbursement. Such rate appeals shall be recognized only to the extent that they are based upon mathematical or clerical errors in the cost and/or statistical data as originally submitted by the medical facility, or revisions initiated by a third-party fiscal intermediary or, in the case of a governmental facility, by the sponsor government, or mathematical or clerical errors made by the Department of Health. Such notice of appeal must be presented in writing prior to or at the exit conference for such audits.

Section 86-1.17 Revisions in certified rates. (a) The State Commissioner of Health shall consider only those applications for prospective revisions of certified rates and any established revenue cap in the current year which are in writing and are based on one or more of the following:

(1) reserved

(2) reserved

(3) reserved

(4) Documented increases in the overall operating costs of a medical facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the medical facility by the commissioner through the certificate of need (CON) process. The provisions of this paragraph shall be applicable with respect to appeals filed with payors, including article 43 corporations and intermediaries responsible as payors for titles XVIII and XIX Social Security Act programs. To receive consideration for reimbursement of such

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costs in the current rate year, a facility shall submit, at time of appeal or as requested by the commissioner, detailed staffing documentation, proposed budgets and financial data, anticipated unit costs and incremental costs for all directly and indirectly affected cost centers, initiated by the approved CON application involving any of the aforesaid activities pursuant to section 710.1 of this Title.

(i) reserved

86-1.17 (1/89)
Attachment 4.19-A
Part I

reserved

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(ii) If after the application of the programmatic and cost analyses, the commissioner determines that the budgeted incremental operating costs are more than 7.5 percent of base year reimbursable operating costs for the rate(s) and rate year being appealed, a facility shall be reimbursed as follows:

(a) Net incremental costs, which are based on budgeted data, shall be determined by the commissioner after programmatic and cost analyses. Such analyses shall include, but not be limited to, a facility-wide review of cost centers directly and indirectly affected by the approved CON project. Such analyses shall result in a determination which limits budgeted costs as follows:

(1) Net increases in staffing shall be evaluated in accordance with the department peer group guidelines. For the purpose of establishing peer group staffing guidelines, at least the following general criteria shall be considered:

(i) number of certified beds;